Amalgamated Life
Group • Stop Loss • Voluntary

Amalgamated Life Insurance Company
Policy Services Department
P.O. Box 7238
Bedminster, NJ 07921
1-914-367-5000

WAIVER OF PREMIUM BENEFITS CLAIM FORM

INSTRUCTIONS: To be completed by a representative of the Fund/Policyholder when an employee is eligible for Waiver of Premium due to a disability caused by accident or illness. Please print or type all answers and return to above address.

Employee's Name ____________________ Last First	Date of Birth _____ _____ _____ Month Day Year
Address ____________________ Street ____________________ City State Zip	Social Security # _____ - _____ - _____
Reason why employee stopped work ____________________ ____________________ ____________________ Benefit Amount of Insurance __________	Date last day worked _____ _____ _____ Month Day Year

Name of Fund/
Policyholder ____________________ Policy Number ____________________

Signature of
Representative ____________________ Date ____________________

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